



## Appendix A

### Guidelines for Performing Level of Care Re-evaluations

	Level of Care Criterion	Guidelines for Review
1.	The person supported needs the level of care being provided and would, but for the provision of waiver services, otherwise be institutionalized in an ICF/ID.	<p>Review the PAE and supporting documentation to verify the diagnosis of intellectual disabilities and to determine if the deficits in adaptive functioning, which served as the basis for the approved PAE, still persist.</p> <p>(Note: If the PAE was approved by TennCare based on a deficit in comprehension and a diagnosis of intellectual disabilities, the deficit in comprehension shall be considered to still persist.)</p> <p>If there is lack of documentation of both intellectual disabilities and significant deficits in adaptive functioning, the person supported may not meet this criterion.</p>
2.	The person supported requires services to enhance functional ability or to prevent or delay the deterioration or loss of functional ability.	<p>Review the PAE, the ISP and amendments since the previous ISP, and current assessments to determine if the person's current services are enhancing functional ability, maintaining the current level of functional ability, or delaying or preventing the deterioration or loss of functional ability.</p> <p>If there is lack of documentation to show that one of the above criteria has been met, the person supported may not meet this criterion.</p>
3.	The person supported has a significant deficit or impairment in adaptive functioning involving communication, comprehension, behavior or activities of daily living (i.e. toileting, bathing, eating, dressing/grooming, transfer or mobility)	<p>Review the PAE to determine the deficits in adaptive functioning that were listed on it.</p> <p>Review the ISP and amendments since the previous ISP for documentation that significant deficits in adaptive functioning still persist.</p> <p>If the person supported does not continue to have significant deficits in adaptive functioning, the person supported may not meet this criterion.</p>
4.	The person supported requires a program of specialized supports and services provided under the supervision of a Qualified Intellectual Disabilities Professional	<p>Determine if the person supported is utilizing waiver services (excluding Support Coordination) and, if not, why waiver services are not being utilized.</p> <p>If the person supported is persistently not utilizing waiver services (excluding Support Coordination), the person supported may not meet this criterion.</p>



## **APPENDIX B**

### **HOME AND COMMUNITY-BASED SERVICES WAIVER**

#### **ANNUAL RE-EVALUATION OF LEVEL OF CARE**

Name of Person Supported \_\_\_\_\_

Social Security Number \_\_\_\_\_

Date of Birth \_\_\_\_\_

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By my signature I certify that the person supported:

1. Needs the level of care being provided and would, but for the provision of waiver services, otherwise be institutionalized in an ICF/ID;
2. Requires services to enhance functional ability or to prevent or delay the deterioration or loss of functional ability;
3. Has a significant deficit or impairment in adaptive functioning involving communication, comprehension, behavior, or activities of daily living (i.e., toileting, bathing, eating, dressing/grooming, transfer, or mobility); and
4. Requires a program of specialized supports and services provided under the supervision of a Qualified Intellectual Disabilities Professional.

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Agency**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Title:** [ ] Qualified Intellectual Disabilities Professional

[ ] Registered Nurse

[ ] Physician